Department of Veteran Affairs **VHA DIRECTIVE 2000-044**
Veterans Health Administration
Washington, DC 20420 **November 14, 2000**

ELIGIBILITY AND EXPANSION OF NURSING HOME CARE

1. PURPOSE: This Veterans Health Administration (VHA) directive implements new eligibility requirements for nursing home care.

2. BACKGROUND: Public Law 106-117, The Veterans' Millennium Health Care and Benefits Act, amended the Department of Veterans Affairs (VA) statutory authority for providing nursing home care to eligible veterans. The new law requires that:

a. VHA provide nursing home care to any veteran in need of such care for a service-connected disability.

b. The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during Fiscal Year 1998.

c. VHA provide nursing home care to any veteran who is in need of such care and who has a service-connected disability rated at 70 percent or more.

d. VHA ensures that a veteran described above, who continues to need nursing home care, is not, after placement in a Departmental nursing home, transferred from the facility without the consent of the veteran or, if the veteran cannot give informed consent, the veteran's designated representative.

NOTE: *Nothing in the new law authorizes VHA to displace, transfer, or discharge a veteran who was receiving nursing home care in a Departmental nursing home as of November 30, 1999.*

3. POLICY: It is VHA policy to implement Public Law 106-117, which amends VA's statutory authority for providing nursing home care to eligible veterans.

4. ACTION

a. VHA shall provide nursing home care, either directly or through contracts, when clinically indicated to a veteran who needs nursing home care for a service-connected disability, and to any veteran needing such care who has a service-connected disability rated at 70 percent or more.

b. VHA may provide nursing home care based on available resources, either direct or through contracts, when clinically indicated to all other eligible veterans who need nursing home care.

THIS VHA DIRECTIVE EXPIRES DECEMBER 31, 2003

c. Patients should be placed in Home and Community-Based Care (HCBC) when clinically appropriate and patients receiving VA Nursing Home or Community Nursing Home (CNH) care will be transferred to appropriate assisted living or home and community-based care settings when nursing home care, at any level, is no longer clinically indicated (see Att. A, Guidelines on Continuity of Care Planning).

d. VA facilities will determine the need for nursing home care based on a comprehensive interdisciplinary clinical assessment.

e. After admission to a VA Nursing Home Care Unit (VA NHCU), veterans described in subparagraph 4.a. may not be transferred or discharged from a VA Nursing Home unless:

(1) The patient no longer needs any nursing home care; or

(2) The patient, or the patient's designee, has given informed consent to the discharge or transfer.

f. VA NHCUs will admit, as a matter of firm priority, patients who meet the following clinical and/or programmatic criteria: post-acute patients, patients who cannot be adequately cared for in CNH or HCBC, and those patients who can be cared for more efficiently in VA NHCUs.

g. All VA facilities will maintain an active CNH Program.

h. When veterans are placed in CNHs outside the Veterans Integrated Service Network (VISN), the VA facility making the placement will authorize care and obligate funds for a period of time not to exceed 3 months. If CNH care is required beyond 3 months for veterans described in subparagraph 4.a., the VA facility which has received the veteran into its Primary Service Area (PSA) will assume the CNH obligations.

NOTE: *Nothing in this VHA Directive may be construed as authorizing or requiring that a veteran who was receiving nursing home care in a VA Nursing Home on November 30, 1999, be displaced, transferred, or discharged from the VA Nursing Home Care Unit.*

5. REFERENCE: Public Law 106-117 dated November 30, 1999 (to be codified at Title 38 United States Code Section 1710A and 1710B).

6. FOLLOW-UP RESPONSIBILITY: Health Administration Service (10C3) is responsible for the contents of this directive.

7. RESCISSION: VHA Directive 2000-007 is rescinded. VA Manual M-1, Part I, Chapter 12, Paragraph 12, 11 is rescinded. This VHA directive will expire December 31, 2003.

Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachment

Distribution:	CO:	E-mailed 11/20/2000
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ATTACHMENT A

MEMORANDUM FROM THE DEPUTY UNDER SECRETARY FOR HEALTH

Department of Veterans Affairs

Date: February 29, 2000

FROM: Deputy Under Secretary for Health (10A)

SUBJ: Policy Guidelines for Continuity of Care Planning for VA Long-Term Care Inpatient Units

TO: All Network Directors; Facility Directors, Associate Directors and Chiefs of Staff

1. As the demand for VA long-term care (LTC) services continues to grow, it is important that we make clinically sound decisions about the appropriateness of care for individual patients. Many VA-operated long-term care inpatient units are moving toward more goal-directed admissions, resulting in greater numbers of patients discharged to home or LTC services provided in the community.

2. These policy guidelines are a reissuance of the November 14, 1997, guidance regarding the transfer of each patient from VA LTC inpatient units. The guidelines stress the importance of the active participation of patients, families and other stakeholders in the decision making process. In recognition of VA's ongoing responsibilities to these patients, the guidelines emphasize transition planning for continuity of care, rather than discharge,

3. They are not intended to provide a "cookbook" approach to discharges from LTC inpatient units; but to delineate the underlying principles of continuity of care planning and the important clinical, patient, family, and institutional considerations that must be evaluated whenever significant changes in the care of an individual are contemplated.

4. This guidance shall be incorporated into the development of all local policies and procedures for long-term care inpatient units.

Thomas L. Garthwaite, M.D.

Attachment

POLICY GUIDELINES FOR CONTINUITY OF CARE PLANNING FOR VA LONG TERM CARE INPATIENT UNITS

PREAMBLE

Inherent in the reorganization of the veterans' health care delivery system is the recognition and growing acceptance that community-based care systems can serve as effective and sometimes preferred alternatives to institutionally-based care. Patients with chronic illness and complex needs who are currently in VA-operated institutional long-term care settings can often have their care needs effectively managed by integrating the resources of multiple community providers, including State Veterans Homes, with VA services. For this to succeed, particular attention must be given to the impact of transitions through the continuum of care on the patient and his/her family.

PURPOSE

The purpose of this document is to provide guidance for managing the ongoing care needs of patients receiving long-term care in VA inpatient units, especially when transitions to other care settings are considered. "Continuity of care" describes the process that begins when a patient in need of long-term care is enrolled. Continuity or, ("transition") planning appropriately addresses the patient's changing needs as the patient transitions through the components of a comprehensive continuum of care.

PRINCIPLES

We should strive to:

Maximize each patient's functional independence.

Make high quality long term care available in the most medically and functionally appropriate location (e.g., home, community long-term care, nursing home, or State Veterans Home) for eligible veterans requiring such care.

Offer equity of access to long-term care, given equal eligibility.

Develop long-term care as an essential component of the continuum of care provided in an integrated health care system.

Consider all effects of a potential transfer or change of venue, especially for patients who have depended on VA-provided long-term care for extended periods of time.

Recognize that, while fiscal constraints and competing priorities exist, transfer decisions should not be based solely on cost considerations.

CLINICAL CONSIDERATIONS

The following are among the key clinical issues or concepts that should be considered when undertaking continuity of care planning:

Ensure stability of a patient's medical and behavioral problems prior to implementation of any transfers across settings.

Set specific and measurable goals and realistic timeframes for their attainment, through the interdisciplinary care planning process.

Relate transfer decisions to the attainment of specific goals for improved function.

Individualize care plans according to the needs of the patient and resources of the family and community.

Use care assessments that are comprehensive, interdisciplinary, objective, and periodically reviewed to track changes in a patient's functional status.

Use interdisciplinary processes to identify the range, intensity and duration of services appropriate to the patient's needs.

Use objective, reliable, and well-validated assessment tools.

Establish core competencies for interdisciplinary staff to manage continuity planning.

Assess the patient's and family's ability to adhere to the post-transition treatment plan in the subsequent care setting, especially if transfer to home is considered.

Discuss and consider treatment alternatives as they evolve with the patient and family, and document these discussions in the medical record.

Maintain continuity with providers. Whenever reasonable, consider ways of delivering care where the patient currently resides.

PATIENT-SPECIFIC ISSUES

When considering continuity of care plans, attention should be given to the following patient-specific issues:

Geographic location of care setting.

Financial resources, including eligibility for Medicare, Medicaid, and other third party payers.

Patient coping skills.

Family support system.

Need for structured settings.

Patient preferences.

Patient decision-making capacity.

Therapeutic and social alliances forged in current treatment settings.

Perceived changes in quality of life after transfer.

FAMILY ISSUES

Collaborative decision-making with families, guardians and significant others best serves the patient since it maximizes family cooperation and participation in transition planning.

In continuity of care planning, due consideration should be given to:

The effects of transition on family members, including any new financial responsibilities.

The availability of respite care, home health aides, and other services that support family caregivers.

The family dynamics, including whether the family has been provident or improvident for the veteran.

Proximity of the family to the care setting.

Prevention of misunderstandings and unrealistic expectations.

Use of due process when dealing with family disagreement with the plan.

PROVIDER-RELATED ISSUES

The provider necessarily functions within an organization that profiles the provider’s clinical decisions concerning resource allocation. When difficult choices occur in an environment of resource constraints, clinicians must:

Exercise reasonable advocacy for patient needs, and

Use an interdisciplinary approach to identify a care plan that is in each patient's best interest.

INSTITUTIONAL ISSUES

Institutional decision-making for continuity of care planning should be principle-based and

maintain a patient-centered focus.

VHA, in its role as a responsible advocate for veterans, must work with veteran service organizations to educate Congressional stakeholders about long-term care issues and needs in the veteran population, including those with specialized care needs.

VHA must be user-friendly for all veterans. VISNs and local facilities should develop a communication strategy which conveys complete and accurate information about health care benefits, including long-term care options, to the veterans' community as a whole.

The enrollment process mandated under recently enacted eligibility reform legislation should be utilized as an opportunity to educate veterans on an individual basis about long-term care benefits and options.
Population-based planning should inform strategies for delivering long term care.

Management boards composed of clinicians in leadership roles and other stakeholders should be convened at the facility level to develop explicit strategic plans, and implement practice guidelines and policies for long term care that are consistent with VISN and national policies.

Appeal mechanisms should be in place to resolve disputes between the treatment team and patients or their families. Consideration should be given to the development of treatment and/or transition contracts.

Local facilities must partner with community long term care providers, including State Veterans Homes, to facilitate best placement options for veterans and maintain excellent communication for continuity of care planning issues.

Institutions and providers are responsible for monitoring the quality of care, patient reported outcomes and patient satisfaction, and functional outcomes following placement. The quality of care provided in community-based settings always must be a paramount consideration.